THE NEIGHBORHOOD HEALTH CENTER*

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I AM particularly pleased to speak to this group on the topic of primary care, since I believe that many neighborhood health centers (NHC) have been in the forefront of the development of the concept. Primary care clearly is an idea whose time has come. The Johnson Foundation is funding it, conferences are being convened to discuss it, and scholarly articles are being written to define it. Neighborhood health centers, I like to believe, have been providing primary care for many years, although we did not know how to describe what we were providing.

First, a bit of history about the NHC movement. The concept is not a new one in the United States. Early in the 20th century there was quite a movement of small, community-oriented, ambulatory clinics which stressed preventive and comprehensive services; I believe that some of these persisted until the depression of 1929. The concept was revived by the office of Economic Opportunity (OEO) in 1965 as one of several attempts by that agency to break the cycle of poverty. Many evident weaknesses in the health-delivery system then available to the poor were felt to contribute to their ill health, consequent inability to work, and poverty. These weaknesses included: lack of continuity of care; failure of follow-up; inadequate preventive care; framentation of services; inaccessibility of care because of distance, financial constraint, or the fear of large institutions; and reliance on high technology and low interpersonal interactions. At the time all of these appeared to be of major significance in the failure to provide high quality health services to the country's poor.

Unfortunately, there is no single model which one can describe generically as the NHC approach to primary care. Some NHCs do not provide primary care at all, if one defines it as I shall, while other outstanding NHCs do. Although some attempts at standardization of care were made under the OEO

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prior to 1969—specifically, the attempt to introduce team care into the centers—several different models have grown up. Some NHCs, such as the Dr. Martin Luther King, Jr. Health Center (MLK) in the Bronx, from the beginning have emphasized strongly the use of primary-care health teams. Others have developed along lines similar to multispecialty group practices, and some, unfortunately, have duplicated the hospital outpatient-department model with multiple, mutually independent clinics and no attempt to achieve coordinated care

My definition of primary care, adapted from that of Lester Breslow, which reflects our distinctive practice, is as follows: Primary care comprises the majority of services necessary for the maintenance and restoration of health, and is available close to where people work or live. It is concerned with the longitudinal, continuous care of health and disease over time and includes responsibility for the continuum of care, that is, maintenance of health, evaluation, and management of symptoms and disease and appropriate referrals.

Given that definition, how can one determine if a practitioner or institution in fact is delivering primary care of high quality? First, certain forms of care are sometimes mistaken for primary care. Although largely ambulatory, primary care is not synonymous with ambulatory care. The ambulatory care provided by ophthalmologists, neurosurgeons, cardiologists, and many practitioners of general medicine is not primary care. Any practitioner who limits his practice by disease, organ complex, or sex is not practicing primary care. The general internist who will not treat simple conditions of the skin, eyes, ears, nose, or throat, minor orthopedic complaints, low back pain, problems involving human sexuality, simple gynecologic problems, or problems related to contraceptive techniques is not providing primary care.

In addition, primary care is not synonymous with first-contact care, although it obviously includes much of it. The first-contact care provided in emergency rooms, in limited facilities such as well-baby clinics or family-planning clinics, and in many hospital outpatient departments is not primary care.

Having excluded the obvious nonprimary-care providers, how can one evaluate the others? How does the NHC measure up to the general internist in solo practice or the multispecialty group practice? A number of criteria drawn from my definition are pertinent in making such a comparison:

1) Is continuity of care provided, either through a single provider or a tightly organized team of providers?

2) Is the care accessible, i.e., is routine care available outside of working hours; is there night, weekend, and holiday availability; is home care available for the incapacitated; and are the financial barriers or the image of the institution small enough not to limit accessibility?

3) Is there inpatient and outpatient provider continuity or, at a minimum, coordination?

4) To what degree does the provider or the institution assume responsibility toward patient follow-up and compliance? (This may vary from no attempt whatsoever to follow-up a patient to an extensive outreach program to locate new patients in need of care.)

5) To what degree does the provider have a holistic approach to the patient's social and emotional problems as well as to his disease problems?

6) To what degree does the provider concentrate on preventive and educational services in addition to curative services?

7) To what degree is the provider sensitive to the satisfaction or perceived needs of the patient?

8) To what degree is the provider concerned with and systematically evaluating the quality of care which he renders?

As judged by these criteria, many NHCs are providing excellent primary care. Continuity, accessibility, and sensitivity of care have been important concepts in the development of NHCs. NHCs are virtually the only institutional providers of care which have attempted to develop systematic outreach programs to follow-up patients, to insure compliance, and to reach patients who, for whatever reason, have not chosen to enter the care system. Preventive and educational services as well as a holistic approach to the patient's problems also have been integral to our development. Finally, NHCs now are developing quality-assurance programs at a time when most providers of ambulatory care have not begun to perceive the need for such programs.

Another important facet of primary care which we are only beginning to develop is in the area of continuing education for the primary-care practitioner. Most physicians in recent years have been led during the course of their training to pursue a subspecialty interest. Increasing technology and the academic orientation of most house-staff programs have encouraged this trend. Since the medical economy can support only so many pediatric neonatologists or adult hematologists in full-time subspecialty practice, many internists and pediatricians have been forced to practice a form of primary care while maintaining basic allegiance to their subspecialty. In our experience this situation generally has led the physician to ongoing education directed to

the pursuit of the subspecialty interest. Only recently we have realized that the pursuit of a subspecialty and the practice of high-quality primary care are somewhat contradictory. The general internist who practices primary care much more often will face situations where knowledge and skills in the area of office gynecology are important than where the knowledge and skills of a sophisticated hematologist are called for. Similarly, simple dermatologic and orthopedic complaints will far outweigh cases requiring evaluation by a highly qualified cardiologist. When reviewing our records at MLK, I occasionally am appalled at the frequency with which relatively simple complaints in these areas are misdiagnosed and improperly treated by otherwise competent personnel in our center. As a result, at MLK we have begun exploring a concept in the ongoing education of physicians which I believe will prove to be crucial to the provision of high-quality primary care. If we follow through on this, physicians will be free to work in a variety of areas outside that of their basic disciplinary identification. We already have begun this by providing a series of lectures in office ophthalmology to our internists and pediatricians; we hope to extend this plan to include systematic clinical experience in gynecology, psychiatry, and other specialties.

Summary

Primary care is a field of considerable sophistication; it requires practitioners who are trained and experienced in the peculiar demands of long-term, comprehensive care of patients and families. Its successful practice requires that the physician be willing to expand his horizons to meet the needs of the patient, rather than forcing the patient to contract his problems to fit the interest of the practitioner. Primary care is a demanding and often emotionally exhausting specialty, but frequently it is also a very rewarding one. The caring environment fostered by most NHCs provides a particularly supportive environment within which primary care may be practiced.